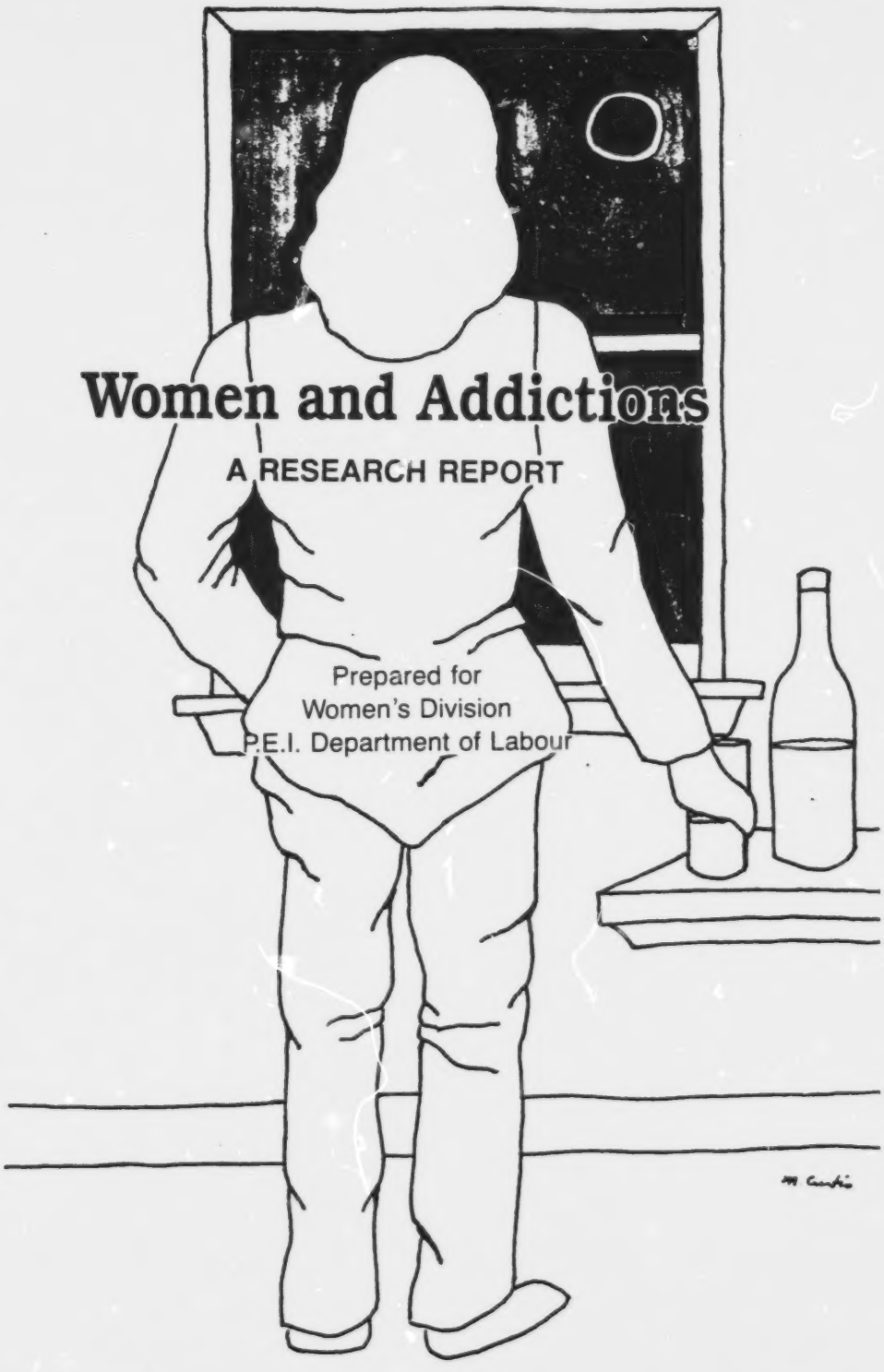

Women and Addictions

A RESEARCH REPORT

Prepared for
Women's Division
P.E.I. Department of Labour

Compiled and written by
JOANNE INGS, B.A., Dip.P.A.
March 1988

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"I HAD NO SELF-ESTEEM AND NO SELF CONFIDENCE.

I WAS VERY CONFUSED, SCARED, AND MORE IMPORTANT, A VERY ANGRY

WOMAN. THAT ANGER LED ME BACK TO DRINKING MANY TIMES."

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1. OVERVIEW

A. Historical Background

There have been people with addiction problems ever since the first addictive substances were identified centuries ago. Substances like opium leaves, fermented drinks made from fruit and herbal aromas calmed the hearts but caused more problems than they solved. As time went on, the problems, the pain and the disruption in the lives of those who suffered from an addiction were often hidden from society and misunderstood by those who were affected by it. It was much easier to make judgments and legalize morality than is was to seek understanding, educate the population on addictions, or treat those who had addiction problems.

Addiction to alcohol is undoubtedly the best known and most studied form of addiction. The pendulum of societal opinion has swung from free access to

controlled purchase in terms of avialability of alcoholic beverages to the general public. Each swing has brought its own innate set of problems and conditions. The current form of control of the sale and consumption of alcoholic beverages has proven to be a very profitable business and source of taxation for both federal and provincial governments.

Recent statistics show that alcohol sales generate 7 billion dollars annually in the Canadian economy of which 3 billion finds its way into government coffers accounting for more than 20% of total revenue. Spinoff effects include 20 thousand people working directly in alcohol production and related industries that depend heavily on alcohol; agricultural sales of grain and grapes amount to 140 million dollars each year; and, 150 million dollars or more is spent on media purchase or advertising. (1)

In the provincial area, for example, "in 1982-83 revenues in the provinces exceeded 2 billion dollars. These dollars were collected primarily through taxes charged on the purchase of alcohol with the breakdown by percentage of 72% on spirits, 45% on beer and 54% on wine." (2)

On Prince Edward Island, the sale and consumption of alcohol and licensing of establishments has proven over the years to be a very profitable business.

The following chart lists the cash sales and net profit of the Prince Edward Island Liquor Control Commission for a 10-year period beginning 1977-78. In that year there were 152 licensed outlets, 12 government owned retail stores and 1 wholesale warehouse. In the final reporting year, 1986-87, there were 277 licensed outlets, 13 government retail stores and 2 warehouses.

P.E.I. LIQUOR CONTROL COMMISSION REVENUE (Table 1)

	TOTAL CASH SALES	NET PROFIT
1977-78	$ 24,287,799	$ 6,482,257
1978-79	25,258,836	6,688,570
1979-80	27,602,661	7,506,780
1980-81	29,992,380	7,819,513
1981-82	35,072,507	7,313,442
1982-83	38,904,314	7,906,428
1983-84	41,303,258	8,385,392
1984-85	43,363,896	8,617,835
1985-86	44,065,615	8,544,146
1986-87	45,514,685	8,927,004

* Source: PEILCC Annual Reports

B. P.E.I. and Addictions

The abuse of alcohol and its devastating effects on many Islanders prompted the Government of Prince Edward Island to take responsibility in developing treatment programs and facilities for those members of its population suffering from alcoholism. In 1966 the Alcoholism Treatment Foundation Incorporated was established by the government of the day. In 1970 the name was changed to the Alcoholism Foundation of P.E.I. The recognition of other mood altering drugs like tranquilizers and street drugs moved the government in 1973 to rename the Foundation the Addiction Foundation of P.E.I. In 1975 the Foundation was designated a Crown Corporation, and in October of 1980 it was reorganized as P.E.I. Addiction Services, and treatment services were contracted out with County Agencies.

Government was not the only body to recognize the needs of addicted persons. Community organizations like Alcoholics Anonymous and its various programs - Alanon and Alateen - had been providing service to the public for many years, often in co-operation with treatments offered through Addiction Services. Also, the crippling effects of alcoholism and other addictions within the family unit were recognized by such organizations as the Protestant and Catholic Family Services Bureaus, religious congregations and other community social service agencies.

In 1984 the Legislative Assembly of P.E.I. struck a committee to consider and report on the Quality of Life on Prince Edward Island. The impetus for this committee stemmed from concern which arose in the House over

the conditions in which some Islanders had to live their lives. Details of these conditions usually came to light during debate on budgets of government departments and agencies. During its public hearings, the Committee heard from groups and individuals who expressed the need for improving the quality of life for Islanders and recommended ways in which improvements might come about.

The Committee reported that the most common problem affecting the quality of life on the Island was the incidence of alcohol abuse among the population. The impact of alcoholism on the family and on the community at large was wide ranging and widespread. In the Committee's report of May, 1984 to the Legislative Assembly it was stated that:

> "The cost of alcoholism and drug dependency to individuals, their families and the society around them is high. The Committee heard that the damage caused by alcoholism is increasing. Agencies treating addictions are seeing more females and more young victims than in past years. Existing treatment facilities, primarily for males, are stretched to the limit, and the need for a new facility for women and youth is severe." (3)

C. Recognition of Need for Services

In the Annual Report of Addiction Services 1981-82, the Director of Prince County Addiction Services made particular reference of a 5% increase in female admissions experienced by that agency. The Director also stated that "Women reported a combined use of alcohol and tranquilizers three times as frequently as men - 24.7% to 8.4%." (4) The concern over the increase in female admissions was again brought forward in the 1982-83 report where it was stated that "Of special note is the increase in the percentage of female admissions from 12.6% to 15.3% in this year." (5)

The Prince County Agency was not alone in expressing concern over increased female admissions and the resulting stress on treatment resources. An evaluation of Addiction Services conducted by Mason Management for the Minister of Health and Social Services in late 1982 reiterated those concerns and stressed the need for improving services for women with addiction problems.

> "There is consensus that women are now being underserved; that a halfway house for women is badly needed; that the rising rate of admissions of women to detox demonstrates the need for improved and expanded residential facilities for women to take rehab programs." (6)

Throughout the report, Mason Management cited examples where services

for women were inadequate or non-existent. The report stated that "There are no addiction services halfway house beds in P.E.I. for women. We conclude that it is a pressing need and that there is considerable support for a solution to it." (7) Each county was requested by Mason Management to identify needed services, and each recommended that a halfway facility for women be a priority. As a result, one of the recommendations of the Mason Report of January 1983 was the need for a halfway house for female patients.

The lack of facilities and services for women was not a problem distinct to Prince Edward Island. On the national level, researcher Linda MacLeod found similar gaps in services right across the country. While compiling information for a report on wife assault in 1986 for the Canadian Advisory Council on the Status of Women, MacLeod surveyed transition house workers in each province and territory. She found that transition houses were usually the only emergency shelters for women in their respective areas or provinces. Transition house workers were often asked by police and social workers to admit women who were intoxicated in public or under the influence of drugs to their facility, as no other services were available or would accept them. Many shelters refused admittance because they were not equipped to handle these emergency patients. MacLeod writes in her report "Battered But Not Beaten" that

> "68% (of transition houses) refused women with active drug dependencies and 66% refused women with active alcohol dependencies. (They) refused these women because they simply had neither the specially trained

staff nor the facilities to deal with them appropriately. . . . workers were disturbed at the lack of services available for them." (8)

These findings are confirmed by P.E.I.'s transition house workers. Anderson House staff have been requested by police and social workers to admit women under the influence of alcohol or drugs due to the fact that the House is the only emergency facility for women in the province. In one case, a woman was admitted because her social worker agreed to stay and care for her. The House has a policy of not admitting intoxicated women because they do not have the ability to care for themselves. A requirement of admittance to Anderson House is that a woman must be able to look after herself and her children.

For several years, the identification of the gaps in addiction services for women has come from a variety of sources. Addiction Services workers, management consultants, social agency personnel and a variety of community groups and individuals have spoken through such vehicles as annual reports, ministerial reports and presentations to legislative committees.

2. PROVINCIAL SERVICES

A. Treatment Programs

Treatment programs on P.E.I. have traditionally taken a three-level approach: detoxification, rehabilitation and short/long-term care. The first level - detoxification, or detox - is the treatment for the withdrawal from the addictive substance. The patients are supervised by trained medical staff, and education about addictions and motivation to continue treatment are an integral part of the program. The length of stay will vary according to the type of addiction - it may be 5 or more days for alcohol detox, 10-15 days for tranquilizers and up to 3 weeks for narcotics.

Rehabilitation, or rehab, is the next step in treatment which usually lasts up to three weeks. To enter this phase, patients must be detoxified from all chemical substances. There are regular group therapy sessions, Alcoholics Anonymous (A.A.) meetings, counselling sessions and other education programs. Patients learn about chemical dependencies and develop guidelines for successful recovery.

Short/long-term care programs (also called halfway programs) are often on a residential basis where the patient lives from one to six months in a controlled environment. The patient attends daily group sessions, goes to A.A. meetings and learns new behaviours for living free of chemicals. Later in the program, the patient may be employed outside the facility but still be a resident.

There are also variations of these three main treatment programs. At the detox level for example, there may be emergency servics offered for people actively under the influence of their addictor. Most standard detox programs will not accept patients who are under the influence of their addictor at the time of requested admittance.

Rehab programs have many variations. Some services may offer both residential and outpatient programs. Programs may be offered daily (8:30 - 5:00) while others may be mornings only. Membership in rehab groups may fluctuate or a patient may go through the program with the same group members.

Short/long-term care programs are available on an outpatient basis as well and are known as aftercare programs. These programs are usually organized in group form which meet once a week for six months to one year.

Many services offer programs focussing on the families of addicted persons by helping them understand addictions. Some programs are offered for children of addicts while others support the spouses, partners of friends.

Adult Children of Alcoholics groups are forming all over North America. In these groups, individuals are confronting, as adults, their feelings about growing up in a home with a chemically dependent parent.

B. TEN-YEAR STATISTICS

Addiction service on Prince Edward Island has been offered on a county basis for a number of years so patients seeking treatment would not have to be very far removed from their home area. For this statistical view, the (1) numbers of beds available, (2) numbers of admissions, (3) revenues and expenditures and (4) board/management composition are charted for the last 10 years.

Chart 1 ADDICTION SERVICES - NUMBERS OF BEDS (Table 2)

	KINGS						PRINCE						QUEEN'S					
	Detox		Rehab		½ Way		Detox		Rehab		½ Way		Detox		Rehab		½ Way	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1977-78	10	2	-	-	-	-	15	2	-	-	10	-	20	-	12	-	16	-
1978-79	10	2	-	-	10		15	2	-	-	10	-	20	4	-	-	16	-
1979-80	10	2	-	-	10		15	2	-	-	10	-	20	4	-	-	16	-
1980-81	10	2	10		-	-	15	2	-	-	10	-	20	4	12	-	10	-
1981-82	10	2	10		-	-	15	2	-	-	10	-	20	4	15	-	21	-
1982-83	10	2	10		-	-	15	2	-	-	10	-	20	4	15	-	21	-
1983-84	10	2	-	-	10	-	15	2	-	-	10	-	14	8	16	-	21	-
1984-85	10	2	-	-	10	-	15	2	-	-	10	-	14	8	16	-	21	-
1985-86	10	2	-	-	10	-	15	2	-	-	10	-	14	8	16	-	21	-
1986-87	10	2	-	-	10	-	15	2	-	-	10	-	14	8	16	-	21	-

* Source: Annual Reports

Chart 1 notes:

When figures appear in the median between male/female columns, it denotes that there was no distinction according to sex presented in the Annual Report. Over this time period, the number of beds available did not change at all in either Kings or Prince Counties. In Queens County a change occurred when the service moved from the University Avenue location to the current location in the Dr. Eric Found Centre, McGill Avenue in 1981-82. The number of beds available for females in the Queens County Detox Centre did increase, as did the number for males with the inclusion of the Police Unit (or emergency service) at the McGill Avenue facility, a service available only to males.

It is important to note that beds for females in residential rehab and detox in Queens County are shared and therefore are not charted as separate and appear only in the detox column. Also, it is important to point out that there were no female beds in any county for halfway treatment except for some which were designated in Kings County in the late 1970's. The number of specific beds for females was not identified, so the number of beds appears midway between the male-female distinction. Female specific beds were not identified at the Special Assessment Unit for two years, although female patients were admitted and identified.

As well, this chart does not take into account the fact that some facilities can expand the number of beds available for females when demand warrants. Those expanded figures are noted in the following section of this report, Current Services.

Chart 2 ADDICTION SERVICES - ADMISSIONS (Table 3)

	KINGS						PRINCE						QUEEN'S					
	Detox		Rehab		½ Way		Detox		Rehab		½ Way		Detox		Rehab		½ Way	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1977-78	312	9	-	-	-	-	902	88	-	-	46	-	862	84	95		63	-
1978-79	434	19	-	-	49		836	76	-	-	49		774	81	-	-	81	-
1979-80	587	24	-	-	36		748	77	-	-	45	-	705	90	-	-	73	-
1980-81	524	16	31		18	-	680	53	46		47	-	739	92	154		98	-
1981-82	555	21	100	3	-	-	674	97	125	48	51	-	854	129	236		152	-
1982-83	592	14	103	3	-	-	673	121	107	41	57	-	666	119	219	51	106	-
1983-84	579	38	-	-	66	-	734	94	131	23	58	-	662	125	256	55	147	-
1984-85	514	21	-	-	51	-	658	75	147	24	77	-	646	152	291	70	155	-
1985-86	537	27	-	-	45	-	587	88	166	16	93	-	670	144	295	62	161	-
1986-87	499	22	-	-	52	-	557	97	146	25	118	-	610	187	510	126	159	-

* Source: Annual Reports

Chart 2 notes:

Admissions which appear in the median between male and female denote that distinctions according to sex were not presented in the Annual Report.

Chart 2 Notes Continued:

Admission statistics for Queens County rehab are only for the residential program as the breakdown for male/female patients in the out-patient program is not presented in any Annual Report except for 1986-1987 where it is included.

In this ten-year review period, each county service experienced an increase in the number of female admissions to their respective detox programs. In Kings County, the increase in the percentage of admissions ranged from 2.8% in 1977-78 to 4.2% in 1986-87 with a high of 6.2% in 1983-84. Prince County recorded its highest rate this past year with 14.8% growing from an 8.9% admission rate in the first year of the review period. The increase in Queens County ranged from 8.9% admittance rate to a high of 23.5% in 1986-87. It is interesting to note that, while admittances of females to detox programs increased, the number of beds available remained relatively constant.

Chart 3 ADDICTION SERVICES - REVENUE (Table 4)

	PROVINCIAL	FEDERAL	PATIENT FEES	TOTAL
1977-78	1,227,725.	25,000.	12,961.	1,265,686.
1978-79	1,602,183.	85,000.	14,668.	1,707,176.
1979-80	1,807,711.	—	20,236.	1,827,947.
1980-81	2,034,384.	—	15,040.	2,049,424.
1981-82	2,471,247.	52,269.	18,480.	2,541,996.
1982-83	2,759,675.	—	11,656.	2,771,331.
1983-84	2,851,020.	—	13,308.	2,864,328.
1984-85	2,699,684.	—	21,309.	2,720,993.
1985-86	2,791,469.	—	12,310.	2,804,779.

ADDICTION SERVICES - EXPENDITURES

	DETOX	REHAB	SHORT/LONG TERM	TOTAL
1977-78	449,537.	202,008.	164,807.	816,352.
1978-79	547,391.	233,000.	232,823.	1,013,214.
1979-80	828,421.	151,328.	291,894.	1,271,643.
1980-81	897,344.	209,620.	273,676.	1,380,640.
1981-82	1,331,112.	490,230.	484,415.	2,305,757.
1982-83	1,501,771.	555,651.	504,721.	2,562,143.
1983-84	1,623,374.	611,023.	442,371.	2,676,768.
1984-85	1,627,107.	598,670.	338,266.	2,564,043.
1985-86	1,618,136.	650,404.	336,776.	2,605,316.

* SOURCE: Annual Reports Addiction Foundation/Addiction Services

Chart 3 Notes:

Federal contributions to revenue in 1978 and 1979 were through a Diversionary Project of the Federal Department of the Solicitor-General. The intent of the first part of the project was to ease pressure on the criminal justice system placed by chronic alcohol abusers. A Special Alcoholism Unit was established in Charlottetown in May, 1978 to receive intoxicated people picked up by police. The Unit assisted in keeping perpetual abusers from exerting unnecessary pressure on Justice facilities. In the 10 months the Unit was open for use in 1978-79, there were 1,796 admissions. The effect of the Unit was felt immediately in the Justice system as the number of offences for public drunkenness was reduced by 54%.

The second part of the project, the establishment of the Fredericton Farm for long-term rehabilitation, was caught in a financial squeeze. The funds for that project did not come forth until 1981.

Patient fees are for services offered by Addiction Services which are not covered under Medicare and are paid for by the individual patient - for example, private counselling sessions and materials.

Chart 4 BOARD/MANAGEMENT COMPOSITION (Table 5)

	PROVINCIAL BOARD			MANAGEMENT COMMITTEE		
	M	F	TOTAL	M	F	TOTAL
1977-78	11	2	13	9	5	14
1978-79	11	2	13	9	5	14
1979-80	8	3	11	7	4	11
1980-81	4	3	7	7	7	14

REORGANIZATION: OCTOBER, 1980

	MINISTER'S ADVISORY COMMITTEE			COUNTY BOARDS				MANAGEMENT COMMITTEE			
	M	F	TOTAL		M	F	TOTAL	M	F	TOTAL
1981-82	9	1	10	Kings	7	0	7	2	3	5
				Prince	11	2	13	3	2	5
				Queens	6	1	7	5	2	7
1982-83	10	2	12	Kings	7	0	7	1	3	4
				Prince	6	1	7	3	2	5
				Queens	12	2	14	4	2	6
1983-84	9	2	11	Kings	9	1	10	1	3	4
				Prince	6	1	7	2	2	4
				Queens	12	2	14	3	1	4
1984-85 Apr. 84-Jan/85	9	2	11	Kings	8	2	10	2	2	4
				Prince	6	1	7	3	2	5
Jan/85 - Mar/85	8	0	8	Queens	11	3	14	3	1	4
1985-86	8	0	8	Kings	7	3	10	2	2	4
				Prince	6	1	7	3	2	5
				Queens	11	3	14	3	1	4
1986-87	6	1	7	Kings	7	3	10	1	3	4
				Prince	6	1	7	3	2	5
				Queens	11	3	14	3	1	4

Chart 4 Notes:

Previous to the reorganization of Addictions in October, 1980, the Addiction Foundation operated with a two-level system of management - a provincial board which determined policy and direction, and a management committee which operated the facilities and programs. It is important to note the distinct lack of female representation at the board level but the more adequate numbers on the management committee. Those on the management level were, in the majority, professional nurses with the primary responsiblity of staffing the detox units and providing medical supervision of resident patients.

After the reorganization, women in decision making roles became almost extinct and were not represented at all between January, 1985 and March, 1986 on the Minister's Advisory Committee. The same situation was occurring at the County level where very few women were represented on County Boards.

C. Current Services Available by County

As noted in the Overview section of this report, the provincial government in October, 1980 began contracting treatment services through locally operated county services. Each service operates independently but interacts closely with the other county services. They each offer a range of services for addicted persons and their families. The activities of the county agencies are monitored and coordinated by P.E.I. Addiction Services Central Office in Charlottetown. Each county operates its programs on the disease-model approach to addiction treatment. They believe their role is to stop the patient from drinking and/or taking drugs. They do that through strict concentration on the drinking or drug taking by focussing the benefits of non-use. Factors which impact upon that activity are deemed to "defocus" the addict. Each county also offers public education programs and cooperates with the Highway Safety Division by offering programs for impaired drivers and accepts referrals from Probation Services.

Following is a description of each of the county services and the programs offered. Also included are admission statistics for the last year and a chart denoting the specific numbers of beds currently available per program in each county.

Kings County Addiction Services

The Kings County Service operates a 12-bed facility in Souris, an information and drop-in centre in Montague and a 10-bed house in Georgetown. The detox program operates out of the Souris facility and has a total of 12 beds with 2 specifically designated for use by women. When demand warrants, that number can be increased to 4. The average length of stay in the detox unit is 5 days with females having a slightly longer length of stay. Georgetown House is a halfway facility for men only.

Patients who complete the detox program and wish to go into rehab must travel to Queens County for that service since it is not available in Kings County. Between 1984 and 1986, 94 clients were referred to rehab. The service does offer a once-a-week, 6-month-duration followup program for detoxed patients. It is a group therapy program, and it encourages patients to become involved in an A.A. group.

An aftercare program is available for those who have completed a rehab program in Queens County. Meetings are held one a week for one year. There are groups located in both Souris and Montague.

The long-term residential program in Georgetown is not exclusive for Kings County clients. Patients from Queens County are also accommodated in exchange for rehab services. The average length of stay is 50 days and the daily programs include discussions, counselling, A.A. meetings and life skills programs.

Family programs are available in Souris and Montague where participants meet on a weekly basis for 7 weeks.

Prince County Addiction Services

Prince County began its detox service in 1976. Today it has 17 beds in the unit with 2 of those beds specifically for female patients. When demand warrants, 5 more beds (1 is a cot) may be designated for female use if the beds are not already in use. The admission rate for women is 15% and the total occupancy rate is 94%.

The rehab program is operated primarily on an outpatient basis, although detox beds may be used for resident patients. Male patients may also have access to beds at the halfway facility, St. Eleanors House, depending upon its occupancy level. Their group programs are "closed" , meaning a group of twelve stay together throughout the 3 week treatment program. It operates 7 hours per day, 5 days per week for those 3 weeks. If members drop out, they are not replaced. No new members can join a group already in progress. All groups are integrated, but male exclusive groups do appear when there is a lack of female patients to participate. There are no female exclusive groups. Prince County developed their rehab program in 1981, and the admission rates for women have levelled to 15%.

The short/long term residential care program is for males only. It is operated through a 12 bed facility called St. Eleanors House. The occupancy rate is 100%, and the average age has dropped from mid 40's in the early 1980's to 35-36 in the past year. Patients live full-time in the facility under strict supervision for the first month of their maximum six-month stay. They participate regularly in A.A. meetings and receive individual assessment and counselling. Women who require longer term treatment are usually referred to Mann House in Charlottetown, the only halfway house for women on P.E.I. On average, one woman per month has been referred to Mann House. Previously, female patients had been referred to Empathy House in Ottawa.

The County's after-care program is operated as an outpatient treatment where patients attend weekly meetings for a period of one year. The service also offers a family program for those who have family members in treatment. Meetings are held once a week, and the Director noted that more women attend those sessions than men. She also stated that few male spouses of addicted women attend the sessions or actively participate in their partner's treatment program. She said the theory that "for every ten wives who see an alcoholic husband through, only one husband remains with an alcoholic wife" holds true in her experience.

Services for adolescents with addiction problems are handled on an individual need basis, but the Director feels there will be an increased demand for this service when the Young Offenders' facilities become operational in Summerside and Tyne Valley.

Counselling services are offered in West Prince for patients living in

that area. Approximately 40% of the Prince County clients are west of Miscouche.

Queen's County Addiction Services

The Queen's County Addiction service is contracted to the Alcohol and Drug Problems Institute, ADPI, and has a total of 22 beds available for detox patients; eight of these are designated for women. When necessary, six more beds can be used for female patients for a maximum of 14. There is a special assessment unit, often referred to as the "Police Unit", which has 8 beds available for males only. The length of stay for patients varies from 5 days for withdrawal to 10-15 days for tranquilizers and up to 3 weeks for narcotic addiction withdrawal. The average length of stay in 1985-86 was 6 days.

Queen's County offers two types of rehab programs - residential and outpatient. In the residential program, there are 16 male exclusive beds available; female rehab patients share bed facilities with detox. Approximately 15-20% of the admissions are female in the rehab program which lasts for three weeks. The outpatient groups are not comprised of a closed membership as they are in Prince County. New members come into groups at any time during the program, and they individually complete the three-week session.

Talbot House in downtown Charlottetown is a male-exclusive halfway facility with 21 beds. Patients live in a controlled environment designed to

help them live without addictive substances. The average stay is 34 days, and during that time residents identify living problems and increase their life skills. An aftercare and A.A. group function out of this facility as well.

This county also offers an aftercare program as well as a variety of family programs for adolescents, children of alcoholics and spouses or partners.

NUMBER OF ADMISSIONS 1986-87 (Table 6)

	KINGS		PRINCE		QUEENS		TOTAL	
	M	F	M	F	M	F	M	F
Emergency	-	-	-	-	1478	-	1478	-
Detox	499	22	557	97	610	187	1666	306
Rehab	-	-	146	25	510*	126*	656	151
Halfway	52	-	118	-	159	-	329	-

NUMBER OF BEDS - BY SEX 1986-87 (Table 7)

	KINGS		PRINCE		QUEENS		TOTAL	
	M	F	M	F	M	F	M	F
Emergency	-	-	-	-	8	-	8	-
Detox	10	2	15	2	14	8	39	12
Rehab	-	-	-	-	16	-	16	-
Halfway	10	-	12	-	21	-	43	-

* Includes both residential and outpatient programs. Source of data: P.E.I. Addiction Services

D. Out of Province Referrals

There are individual situations where a patient under treatment with one of the County Agencies may benefit from treatment programs offered outside the province. Criteria for referrals are not written down or stated in any policy. Consideration for approval is through consultation between the County Director making the recommendation and Dr. Leo Killorn.

Previous to the reorganization of Addiction Services in October, 1980, there were a number of patients sent out of the province for treatment. The primary reason was the lack of rehabilitation programs on the Island. Patients who required this type of treatment were routinely sent to programs in the United States after initial detox treatment. After the reorganization, facilities were expanded and the need for out-of-province programs decreased. Currently, patients who are recommended for treatment out of province are those whose opportunity for recovery would be greatly enhanced away from the Island. The program utilized primarily by Addiction Services is a 28 day residential program offered by Chit Chat Farms in Pennsylvania. Patients with extreme family pressures or those of a particular socio-economic or professional level which may be distracting or inhibiting to recovery are considered in the referral process.

Those who are recommended for out-of-province treatments have their treatment costs covered through medicare. Transportation costs are not covered and must be paid by the patient. Policy for government payment is that the cost cannot exceed the cost per bed on the Island for similar

service. The Department of Social Services policy authorizing payment for their clients or prospective clients recmomended for out-of-province treatment states that payment will not be approved if a comparable service is available within the province. There were no claims authorized under that policy since it went into effect two years ago. The first approval came in February of 1988 for a female client because of the temporary closing of Mann House.

Statistics offered by Dr. Killorn relating to out-of-province referrals show that between January, 1974 and January, 1988 there were 280 persons referred, 57 of them women. The largest number were referred before 1981, and since then the average has been 4 per year.

Figures from Hospital and Health Services show the following: (Table 8)

YEAR	# OF WOMEN	TOTAL COST	COST PER PATIENT
1985	6	$ 34,595.50	$ 5,765.92
1986	2	$ 14,165.50	$ 7,082.75
1987	4	$ 22,650.79	$ 5,662.70
	—		
	12	$ 71,411.79	$ 5,950.98

* Source: Hospital and Health Services
March, 1988

Figures from Hospital and Health Services show the following:

(Table 8A)

YEAR	NUMBER OF MALES	TOTAL COST	COST PER PATRON
1985	12	$66,894.35	$ *
1986	5	$34,742.77	
1987	4	$22,983.95	
	21	$124,621.07	

* Not available yet; to follow

** Source: Hospital and Health Services
March, 1988

E. Programs for Women

There are no female-exclusive treatment programs or elements of programs in any County Service. Female patients are integrated into treatments. Except for female-exclusive beds in some residential programs, all other elements of treatment are integrated.

According to County Directors, the primary reason for not having any female-exclusive groups at any level of treatment is that there are usually too few women in treatment at one time to warrant establishing one. Most treatment groups function with 12 or more members, and there are rarely fewer than 2 women in a group. Male-exclusive groups do appear when there are no women in treatment.

Spokespersons for three county agencies and the Central Office did not consider female-exclusive groups desirable or necessary for successful treatment. It was felt that the treatment of an addiction had no boundaries according to sex.

There were workers, though, who felt that women did not reap the true benefits of treatment in integrated group situations. They said women often assumed traditional roles in intensive group situations of nurturing and facilitating emotional men. The women's individual needs became secondary to those of the men.

3. COMMUNITY BASED SERVICES

Not all work in addictions is done by government contracted agencies. There are a number of groups, organizations and agencies in the community at large which offer support and services to individuals with addictions. Many work in cooperation with the contracted services and, in some instances, bridge the gaps in existing services.

A. Alcoholics Anonymous

Alcoholics Anynymous (A.A.) was founded in 1935 by a New York stockbroker and an Ohio surgeon with the intention of helping others who suffered from the disease of alcoholism and supporting them in their battle to stay sober. Now a worldwide organization, membership is in the millions with people from all walks of life benefitting from its programs.

> "It is a voluntary fellowship of men and women who meet together to attain and maintain sobriety. It is a program of total abstinence and members stay away from one drink, one day at a time. Sobriety is maintained through sharing experience, strength and hope at group meetings and through the suggested Twelve Steps for recovery from alcoholism.
>
> The Twelve Steps of Alcoholics Anonymous are:
>
> 1. We admitted we were powerless over alcohol -

that our lives had become unmanageable.

2. Came to believe that a Power greater than our own could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to other human beings the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs." (9)

Local workers in the field of addictions say that, without the support of A.A. and its members, many of their treatment programs would lose their effectiveness. As noted in the section on treatment programs in this report, involvement of patients in A.A. meetings is critical and often compulsory in many treatment programs offered by Addiction Services.

Auxiliary organizations of A.A., Alanon and Alateen, provide support and information for families who have an alcoholic member or members. The family programs offered through all the County agencies rely a great deal on these programs. The Alanon group offers support for spouses or partners of alcoholics and, according to addictions workers, they are bringing out other family members who may also have a problem with alcohol and are not able to recognize it. Alateen has a similar support program for young people who may have an alcoholic parent or sibling and need to learn how to cope with and understand the disease.

It is difficult to obtain any statistics on the A.A. movement in Prince Edward Island, as the blanket of anonymity covers all facets of the organization. Through conversations with addiction workers, it is apparent that there are a number of groups functioning in each county. Worldwide statistics released by the organization in 1974 showed that more women were joining A.A. than ever before at the rate of one woman for every three men. Later figures showed, in some areas, the ratio was one to two. (10)

B. Mann House

Mann House is located in Charlottetown and is currently the only halfway facility for women in the province. Organized and operated by a group of community minded citizens, the House recognized the need for a facility exclusively for women, and the goal was realized in May of 1986 when the eight-bed facility was opened.

Focussing on the special needs of chemically dependent women, organizers and staff created a program for women with the objectives:

"1. To provide a facility to enable chemically dependent women to live in a protected environment following initial treatment.
2. To assist in maintaining long-term abstinence from alcohol and/or other chemicals.
3. To provide a re-education program in basic living skills.
4. To assist individuals to find gainful employment.
5. To continue to provide services to maintain and improve physical and mental health.
6. To direct residents toward a stable environment following discharge.
7. To establish and maintain adequate records." (11)

To achieve these objectives, residents participate in group therapy sessions, lectures, presentations, House meetings, volunteer work and health programs. A number of community resource people are utilized from various agencies and organizations as presentors and lecturers. Other community facilities such as the Y and Richmond Centre are used by Mann House residents.

All programs within the House are for women only and the group therapy sessions are facilitated by women. Here residents are encouraged to share personal feelings and be honest about their needs. Participants in the group are all of equal status and have equal time to speak within discussions. Topics in group therapy sessions include self esteem, relationships, dependence/independence, health and nutrition, aging, stress, sexuality and spirituality. Recognizing the commonality within the group and identifying the support needed to achieve personal change are the primary goals of the group therapy sessions. Mann House and its staff were also instrumental in establishing a Women for Sobriety group. Women for Sobriety is a self-help group which promotes the philosophy that recovery is linked to a positive sense of self-worth.

Since Mann House was opened in May, 1986, 42 women have used the facility for a total of 2689 days or an average of 64 days per resident. Referrals have come primarily from each county through the addiction services agencies.

Mann House closed temporarily on January 13, 1988 for renovations. Staff were laid off and no referrals were accepted. It is hoped that this

facility will reopen as soon as possible, as there are again no halfway treatment facilities for women available in the province.

Adequate funding to operate Mann House has been difficult to maintain on a regular basis. The Board which operates the facility has constantly been searching for ongoing financial support. The contracted per diem rate with the Province is inadequate and unrelated to the services being provided. Recent differences between Mann House and the people within Addiction Services have also created problems. While funding, philosophy and relationship problems take centre stage, the people who need the service are relegated to the wings, again victims of a battle over which they have little control or influence.

C. Other Supporting Services

There are a number of other community and government agencies which provide support to addicted persons. Women who are in treatment often, through the course of private counselling, reveal difficult life situations. Some may be victims and are recommended to community agencies like Anderson House or the Rape and Sexual Assault Crisis Centre for information. Those with family problems may be referred to one of the Family Service Bureaus. Community Mental Health programs and services offered by various churches within the community also accept referrals. These services, in turn, also refer their clients to Addiction Services if necessary.

Other government departments, both Federal and Provincial, provide support services as well. Employment training, upgrading and re-entry programs, Departments of Health and Social Services and Justice provide a number of services of which addicted persons may take advantage.

Nice ladies don't drink

"Nothing worse than a drunk woman."

Social disapproval is greater for women problem drinkers than men. This greater stigma reflects the fear that women who drink may no longer exhibit the sensitivity to others needs which is the core of the female role.

4. WOMEN WITH ADDICTIONS

A. Why Women Drink

> "Women drink differently than men, and they drink for different reasons . . . most women do the majority of their drinking at home and alone. It is one of the clearest indicators of the type of environment which begets and fosters alcoholism among women." (12)

Men drink more than women, and there are more men than women who drink. The reasons for consumption are different. Drinking long ago achieved a status of virility for men and how much a male could hold often was the determinant of his manhood.

Males begin to drink at an earlier age than females, and alcohol often acts as a bonding agent between them. Be it a beer after the game, drinks after work or a night out with the boys, our perceptions of men and alcohol versus our perceptions of women and alcohol are quite distinctive and stereotypical. Society accepts a male being drunk, as it is often seen as a "guy letting off some steam" or who has had "one too many with the boys." Men are presumed to be working under a great deal of work related stress and are allowed to alleviate that stress through drinking.

Too often we have heard it said that there is nothing more disgusting than a drunk woman. Some refer to it as the Fallen Angel syndrome.

> "Joseph Hirsh wrote in 'Women and Alcoholism' that "woman represents important social and moral symbols that are the bedrock of society. When angels fall, they fall disturbingly far." As alcoholics they risk society's censure by not conforming to the code of acceptable behaviour for women - that of being the good mother, caretaker of the family, the tie which binds the family together. They add the disgrace of being a woman who faltered. It is these stereotyped roles assigned to men and women in relation to alcohol consumption that is at the root of the stigma of the female alcoholic. There is a double standard applied to alcoholic women when compared to alcoholic men." (13)

It is the social stigma of being identified as a woman alcoholic that drives women with alcohol problems underground. They often retreat into the privacy of their home rather than seek treatment for their addiction or, in many cases, even admit to a problem. Even though society is gradually changing its attitudes on the roles of men and women, we, as a society, still come down harder on the female alcoholic than the male alcoholic, and for no other reason than that she is a woman and we expect more of her.

Linda Rasmussen writes in a special issue of Healthsharing Magazine on Women and Alcohol that "The once popular belief that a woman's drinking problem was precipitated by personal crisis is now in doubt. This idea may

have arisen from the female alcoholic's need to justify her drinking in order to reduce the stigma she felt surrounded female alcoholism." (14)

Many researchers now believe that problem drinking must also be seen as a behavioural problem with the person using alcohol as a way to adapt to the particular stresses in her life. (15) Dr. Gordon Bell of the Donwood Institute in Toronto says that most women drink to relieve boredom, loneliness and frustration. (16) Pressures felt through social conditioning and low feelings of self-worth appear more and more in statistics as reasons why women drink. Drinking as a method of escape is a common and disturbing route for many women. The incidence of violence in the lives of alcoholic women and, in many cases, combined with childhood sexual abuse, is becoming more widely recognized and understood as an element affecting alcohol consumption by women. In a recent edition of Health Promotion, a publication of Health and Welfare Canada, the results of a study by Carleton University School of Social Work Professor, Dr. Colleen Lundy, were reported. It was stated that one of the most striking findings of the study was the amount of violence occurring in the lives of the (alcoholic) woman. " .. they reported using alcohol as a means of escape from alienation, lonlieness and physical and emotional pain, or as a source of solace and support. A clear connection emerged between the drinking behaviour of these women and the social conditions under which they lived." (17)

The working woman often faces a situation of double jeopardy. Working in low paying, dead-end jobs often creates feelings of helplessness and frustration. Add to that the continued primary responsibility for housework

ALCOHOL & VIOLENCE

'Is it the booze that does the beating?'

Violence against women
is twice as likely to
occur in families
with alcohol problems.

**However, alcohol does
not beat women.
It loosens inhibitions;
produces a false
sense of courage;
is used as an excuse.**

and child care. Making it in a "man's world" may also pressure women into assuming the male role of drinking for relaxation after work and as a way of being accepted by co-workers.

The stigma of the female alcoholic is the greatest deterrent to her seeking treatment for her addiction. Because society condemns all women for the failure of one, women alcoholics suffer for their perceived failure of all womankind. Her family will protect themselves from the shame of society by not intervening and will continue to hide the addict for fear of embarassment. The alcoholic woman will not seek treatment because of an attitude of society that puts unrealistic values and demands on the roles defined purely by sex.

Women drink for different reasons than men, and their experience of being alcoholics is different than that of men. Those women who eventually seek treatment do so at a later age, because of the denial, and their recovery period usually takes much longer. Coping with feelings of failure, anger and frustration is as difficult as the treatment and recovery process.

B. Women and Drugs

Women with drug addictions do not suffer the same type of social isolation as do women alcoholics. The primary reason is that most drug addictions stem from legalized prescriptions authorized by a doctor. Addictions arising under a doctor's care seem to be more legitimate or acceptable than those which arise without professional influence, like alcoholism. Twice as many prescriptions for "mood altering drugs" like Valium and Librium are written for women as for men - a shocking but well proven fact.

Research supporting the instance of higher rates of prescriptions for tranquilizers for women has been accepted as fact for over 15 years, based upon landmark studies by Ruth Cooperstock. She found through her research that women were twice as likely to use prescribed drugs as men. The primary reason was the attitude of doctors towards their female patients. Women were said to have more emotional and psychological problems and just needed something to calm their nerves.

In 1976, a London, Ontario study (Bass et al.) revealed that doctors shown case studies of males and females with similar symptoms prescribed quite different treatments. The males received x-rays, tests, diet counselling and physiotherapy; while the female patients were, in a higher precentage, prescribed tranquilizers. Another study completed in the United States in 1979 (Wallen) showed that doctors considered psychological factors

as a component of illness only when the patient was identified as female. These two studies revealed an apparent bias by doctors towards female patients.

The argument that women get more prescriptions because they visit the doctor more often than men distorts the reality of the attitude of the medical profession towards women. Women may receive twice as many prescriptions but they do not visit the doctor twice as often. Medical personnel who still believe that women's ills are mostly psychological or are due to "raging hormones" are the greatest deterrent in attempting to lower the numbers of women who are addicted to prescribed drugs. Ironically, it is this area of addictions which has the greatest potential for change. On P.E.I., Addiction Services workers state that addiction to tranquilizers is the most common addiction found in women admitted to detox programs. One County Director said that tranquilizer abuse and addiction would almost cease if doctors would stop prescribing them for every ill and if women would stop asking for them.

Women's feelings of helplessness and the medical profession's disregard of the realities of many women's life situations can perpetuate an addiction and continue to fuel potentially dangerous situations. An example of this situation is the treatment of some wife assault victims. Too frequently these women are given medications when they complain of being "on edge" or "nervous". Social worker Deborah Sinclair writes in her book Understanding Wife Assault that fear is the most predominant feeling of these women. "It rules her actions and colors her every waking moment. It intrudes and plays

havoc with her sleep patterns causing insomnia and recurrent nightmares. This sleep disruption may lead to dependence on addictive sleeping aids and tranquilizers. (18) Sinclair says that further discussion between the woman and her doctor about the cause of the nervousness could bring a possible abusive situation to light. A helpful response would be discussion of violence and the community resources available to the woman. The unhelpful response, in Sinclair's view, is the doctor's pat on the arm, the tranquilizer prescription and the advice to relax.

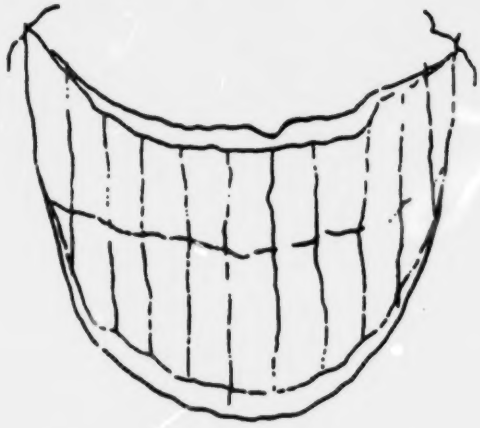
Attitudes of the medical profession towards women are reinforced by pharmaceutical companies and the sexist advertising used to promote their products for women. Advertising slogans like:

"If she could cope, she wouldn't have called",
"When women outlive their ovaries . . . ",
You're the expert and you know who should receive estrogens. . . "
"He is suffering from estrogen deficiency and she is the reason why" (19)

are regular fare on product brochures passed on to doctors by drug companies. These attitudes promote the ideas that women are not capable of making decisions about their health; that the cyclical nature of women's body functions isn't understandable and are at the root of all medical problems; that women naturally have difficulty in coping with life; and that the doctor knows best.

NERVE PILLS ?

'I take them to cope'



Cope with what ?

It's Just Your Nerves. Health & Welfare Canada.

Addiction to prescription tranquilizers is the most common type of drug addiction. Librium and Valium are the most commonly abused tranquilizers. The history of the development of these products comes from a stereotypical pattern of testing.

> "What was to become the product Librium and was to usher in the era of mass tranquilizers was first tested at a zoo on a Siberian tiger resentful of its captivity. . . . The chemical apparently had the desired effect (calm the beast yet keep it conscious and alert). And we can be sure that the company quickly saw the potential market in a society more interested in keeping people functioning, even though they might be suffering from exceptional stress, than in reducing the stress. It is significant that this drug was next tested on the mother-in-law of a company executive. This line of research ultimately led to Valium, or diazepam (to become the world's most prescribed drug) and a whole array of products often referred to in the industry as "housewife's pills". (20)

What is even more alarming is that product testing is done by the pharmaceutical companies and not by outside, independent agencies. They control the testing and the test results. Over 50% of prescription drugs now in use have come into the market without being tested on women. (21) Potential side effects and the effects of long-term usage are unknown in many cases.

Recent studies reported by Health and Welfare Canada show that not much

has changed in the last few years. Women still visit the doctor frequently and are twice as likely to be prescribed mood altering drugs. Because many women feel helpless in the face of their multiple responsibilities, taking a pill deludes them into believing that they are altering their reality. Today, the rate of prescriptions for tranquilizers is still at a 2:1 ratio of women to men. The numbers of women addicted to prescription drugs are not decreasing.

C. Cross/Double Addictions

The attitude of society towards the female alcoholic is perpetuated within the medical community. Rather than confront an alcoholic patient about her problem, many health care professionals will deny and excuse the problem. Too often the reputation of the family or spouse, or potential effect on the children are used as excuses for not recommending treatment. To complicate matters, the addition of tranquilizers as a form of treatment or attempted replacement of alcohol can create the problem of a cross or double addiction. For women, the most common combination of a cross or double addiction is alcohol and prescribed tranquilizers.

This scenario was well documented in a recent edition of Ms. Magazine focussing on women and addictions. In the article, Patterns of Addictions, Pam Jones writes that "Doctors frequently misdiagnose female alcoholism and

drug addiction as depression - and in the process often end up prescribing drugs that make the situation even worse." (22)

Alcohol is the common denominator in many double addictions. Alcohol combined with street drugs such as marijuana, hashish, cocaine, crack or heroin are often found in younger addicts but not exclusively. Addiction to a street drug is often not limited to one drug. Prescription drugs like Valium and Librium, obtained illegally and in varying forms, are frequently appearing in young people admitted to drug treatment. Other drugs like PCP, LSD AND "designer drugs" with exotic names like Black Beauties and Wise Eyes are appearing locally as well.

In Kings County, for example, the most common double addiction is alcohol and marijauna. In Prince County, the combination is alcohol and illegal tranquilizers. These addictions are frequent, particularly in young women admitted to the Counties' detox programs.

The treatment of an addiction is made much more difficult with the inclusion of another substance. The constantly changing combinations and chemical qualities in street drugs make it difficult for researchers to provide current information to addiction workers.

5. TRENDS AND DEVELOPMENTS

Until the early 1970's, there was very little research directed towards women with problems of addiction. Studies on alcoholism tended to include women only to the extent where "their attitudes and behaviour might affect the lives of male alcoholics". (23) Those working in the field of addictions believed that chemically dependent men and women were much the same except that there were more men than women. Treatment programs and prevention strategies were determined on male need and usage patterns, because supporting research was based on male subjects. This is not to discount or refute decades of research on alocholism (the major area of study), but to point out that women as addicts were not studied as a spearate or majority group. Literature reviews from the United States and here in Canada pointed to "a sex bias in existing research and to a lack of attention to women's unique needs". (24)

The growth and impact of the Women's Movement in the late 1960's brought the issue of women and addictions to the agenda of health care advocates and researchers. The distinct lack of research focussing specifically on women, combined with growing numbers of women joining Alcoholics Anonymous and entering treatment programs,prompted addiction researchers to study women as a separate group of addicted persons.

A. National Recognition and Concern

In Canada, national consultations focussing on women with addictions began in 1975. The National Consultation on Alcohol and Drug Use Among Women and the Ontario Consultation on Women, Alcohol and Other Legal Drugs were the forerunners to, and the initiators of, many similar meetings across the country. From these and other meetings a "picture began to emerge of the characteristics of women with alcohol and drug problems, the extent of the problem, societal attitudes, and the availability of resources". (25)

Conflicting statistics brought more questions. In the mid 1970's, the ratio of male alcoholics to female was 6:1 but attendance at A.A. meetings was 3:1. Ruth Cooperstock's study on women and prescription tranquilizers showed that women were receiving twice as many prescriptions as men and that women were becoming cross addicted. Discussions brought to light the social stigma women faced as alcoholics. Stereotyped attitudes perpetuated by family and professionals encouraged women to deny their addiction rather than seek treatment for it. Since women were not seeking treatment, programs and facilities for them were not being developed.

<u>An Ultimate Catch-22 Situation</u>

The woman who is an alcoholic is looked down upon by society ("There is nothing more disgusting than a drunken woman!"). Her family hides her problem because they are embarrassed and do not encourage her to seek treatment. Since she doesn't seek treatment, the demand for

services is not realized. If she does go into treatment, she will probably be faced with workers who perpetuate society's stereotyped roles and images of women. She may go to her doctor to get something to calm her nerves so she won't drink so much, and the doctor prescribes tranquilizers. The probability of a cross addiction develops. Nobody in this whole course of action asks why she drinks.

The national and regional consultations held between 1975 and 1979 brought the issues impacting upon women with chemical dependencies into focus and established a common ground for discussion. The recurring theme throughout this time was the need for analysis of women's addiction problems within the context of their role and status within Canadian society. A statement, endorsed by all delegates to the Ontario Consultation in September 1975 read:

> "It is the premise of this Consultation that many problems currently presented by women to health care professionals as individual problems are, in fact, social problems requiring social rather than chemical solutions. We believe all attempts at prevention or treatment will be largely inadequate if the social structure, which limits women's full participation in society, is not changed." (26)

In 1979, Health and Welfare Canada developed a kit called "It's Just Your Nerves" in response to the recommendations from the Ontario Consultation. Originally intended to educate health care professionals, the kit; which

contained flipcharts, guidebook and film; became an educational tool for the grassroots across the country. Facilitators were trained in each province, and thousands of people participated in discussions generated through presentation workshops. Awareness and understanding of the issues surrounding women and addictions grew as did the agitation for recognition and change. The kit has been used as a resource in addiction courses and as a source for discussion in treatment centres. Its primary goal of encouraging informed discussion by giving women factual information about alcohol and tranquilizers and broadening understanding of the social complexities underlying their use certainly was achieved. (27) Many groups initiated action after participating in a discussion group using the kit.

B. Development of Programs for Women

Traditional treatment programs and prevention strategies are based on male orientated and disease orientated models. Education programs like Health and Welfare's "It's Just Your Nerves" promoted looking at the issue of women and addictions as one separate from men and included the impact of gender based roles on the addict.

In the section, Women with Addictions, the effects on addicted women of socially defined roles and stereotyped images of what women were "supposed" to be were outlined. Anger, fear, depression, anxiety and lack of self-worth were common feelings experienced by women as chemically dependent persons.

They drank because of frustration with the lack of life choices and were victims of a double standard when it came to acceptance and treatment of their addiction. Addicted women were not fulfilling the expected role of wife and mother and were failures in the eyes of society. Addiction workers were usually victims of social stereotyped attitudes as well. Treatment programs were male based and often not available to women. Consideration of the special needs of addicted women was not taken into account. Daycare facilities, employment upgrading and assertiveness training were not part of treatment programs. Numbing reality through the use of alcohol and/or drugs did not alter the reality of addicted women's lives.

The stress created by pressures to conform to society's expectations was often unrecognized as a factor influencing an addiction.

> "From childhood, society has taught women to develop a sense of self-worth mainly through relationships with men, rather than through achievements and activities of their own. Society has tended to define quite different roles for women and men and these produce different behaviours, goals, self-images and life experiences. As a result, women share problems that men do not." (28)

More so today, women are encouraged to develop as independent persons with strong, secure identities. But maintaining the traditional role is still very desirable and often reinforced through the glorification of the wife and mother roles. Strong minded, independent women are still a threat to the status quo. Pressures created by a society which frustrates an

individual woman's choice of role determination are great and, very often, destructive.

The development of treatment programs and strategies has been a slow and frustrating experience for those actively working with and advocating for addicted women. The challenge has been, in the words of Marilyn Keddy, the Regional Director of the Health Promotion Directorate, "to meld the social analysis with traditional practices and support; to empower chemically dependent women; and to design and establish programs which support women making choices." (29) Keddy made this statement at a conference held in Charlottetown in September, 1987 focussing on women with chemical dependencies.

The need for treatment programs for women to focus on more than just the disease of addiction was brought forward more than 10 years ago. Researchers Ruth Cooperstock and Henry Lennard stressed in their 1977 paper, "Social Meanings of Tranquilizer Use", that it was necessary to look beyond the medical model of disease to the structural factors creating the stresses. (30) It was also suggested by writer Judy Fraser that females should be treated by individuals concerned and informed about sex-role conflicts of women in society. (31) The challenges to traditional treatment programs became more frequent as the recognition of the differing needs of men and women were realized.

> "Historically, treatment programs trained men to take responsibility for their lives and trained women

to take responsibility for the men in their lives. . . . Programs which will make a difference are those which develop innovative ways to reach women - mutual aid groups which focus on identity, assertiveness training, vocational and career counselling, and daycare services. Most important of all is the staffing of these programs by people who recognize women's potential as individuals whose independence must be supported as a vital plateau between past dependence and future independence." (32)

Dr. Jean Kirkpatrick was a keynote speaker at the recent provincial conference on Women and Addictions sponsored by Mann House, the only halfway treatment facility for women on the Island. In her address, she spoke about women who needed special help in the treatment of their addiction. She told delegates, "Women need special treatment programs for alcoholism and more respect from society so they'll feel better about themselves. Society must value women more than it has. Look at their pay cheques." (33)

Successful recovery of women addicts is the primary goal of those working in the field of addictions. The challenge is to secure support for programs where women can find support to necessitate changes that will put them on the road to recovery, according to Marilyn Keddy of Health and Welfare Canada. (34) The integration of feminist therapies into treatment programs is the key element says Dr. Susan Penfold of the University of British Columbia School of Psychiatry. At the 1986 National Consultation on Women and Drugs, she outlined the basis of feminist therapy.

"Feminist therapy assumes that ideology, social structure and behaviour are all inextricably interwoven. It conveys understanding of the invidious nature of sex-role stereotypes and attempts to help a women free herself from them and go on to achieve her own potential. The differences in power between the therapist and the client are minimized as far as possible, the client's strength and competence are emphasized and facilitated, and the creation of dependency is avoided, as is the reinforcement or creation of guilt and blame." (35)

The development of the sense of self is the critical element in treatment programs for women. Combined with the identification of the power and impact of social structures upon women, the path to understanding and living with an addiction may not be as difficult or frustrating for the chemically dependent women. The road to recovery may also be much more successful.

6. WOMEN SPEAK

One can write volumes on addictions. Statistics, programs, historical analysis, facilities, philosophies can prove facts and make points. But the experience of a person who lives with an addiction on a day by day basis often tells the real story. Here are two such experiences. The first one was written by a woman who lived in Mann House for a period of time, and it tells of her feelings. The second is the account of a woman who within the last month (February, 1988) began treatment.

ANDREA'S STORY

I came to Mann House August 7, 1986, a very battered woman emotionally and mentally. I had no self-esteem and no self-confidence. I was very confused, scared, and, more important, a very angry woman. I think it's important to talk about the anger - anger turned out to be what I got the most help with. Anger led me back to drinking many times.

While I was at the House, we did about six weeks work on anger, and this helped me tremendously. I also worked on putting my past where it belonged - in the past. For example, my marriage. I did my own divorce while I was in the House.

Another area I got a lot of help in was through the basic structure of the program in the House. My life certainly lacked structure, and so I was able to learn to put structure into it. Discipline was another thing I needed in my life, and I learned to practice this.

One-on-one counselling was another thing I got while staying at the House, and it was very important to my staying sober. This counselling continued after I left the House, and I still receive it today. Through this I have grown and gotten stronger. I have gotten to know myself better and can like me and see who I really am. Before I had no sense of myself.

Another benefit of the House was the support of the other residents who could understand because they too were going through what I was. If I was down or when some days were rougher than others, the other women would give me a hug or take the time to listen. I needed this to help me hang in there until I worked through those days.

All this help I didn't get right away. The first month I was at the House I was not open to help. I was very angry and did not want to be there. Because of the love and caring from the staff at the House, I became receptive to the love and help available there. I blossomed from then on with a lot of love, guidance and plain hard work.

Since then there has been a lot of trial and tribulation, but I am now working on an ongoing program of counselling and meetings and have the support of the house.

Hence, I would say that my life has turned around since coming to Mann

House. I owe the House a lot and the staff and residents were my lifesavers. Today I'm enjoying life. I enjoy being a mom to my beautiful little girl. I enjoy working and am trying to give back to other people coming through the House some of what I received.

Today I have a sense of myself and feel like I know a bit about myself and that I have rights and deserve to know them and be able to exercise them. I have some self-esteem which still needs work, but I have a lifetime to develop it fully. I have some self-confidence and can at least attempt to do some things I wouldn't have in the past. I have the capabilities today to assert myself as in the past I was incapable.

So today you can see I have gained a lot from going through Mann House. It has opened up a whole new life to me.

BETH'S STORY

Beth is a woman in her early forties. She has a university education and a good job. She began drinking in high school and drank regularly every weekend at university. She liked the way she felt when she drank, and it seemed that everyone liked her in that condition. When she began working, the drinking continued, but she was smart enough not to let it interfere with her work. Only twice did she go to work with a hangover, and she never lost a day of work because of drinking.

She felt more comfortable when she drank. She could get away with outrageous behaviour, her friends would always look after her and she could say what was really on her mind.

As a young girl, Beth was sexually molested by a neighbour and was never able to talk to anyone about the experience. Early visits with psychiatrists proved more damaging than helpful. They were never able to bring Beth out of her shell. They gave orders to stop drinking, stop smoking and stop hanging around with the wrong people and that would cure her. For Beth, it seemed that the only way to exorcise the demons she felt within her was to get drunk and talk all around it. She felt that she could then deny anything she said because she had been drunk.

Finally she talked to someone who understood her pain of being sexually abused so many years before. Even though she was drunk at the time she still made the commitment to talk again in a sober state of mind. Her attempts to

hide her feelings of fear, shame and guilt through alcohol became understandable.

She still, at times, fought the processes she agreed to in therapy sessions and again drowned her frustrations in alcohol. Members of her support group told her that she was not pulling her weight in the group and asked her to leave. Members of this support group had responsibilities to one another, and Beth was reneging on hers.

The loss of this support group drove Beth again to drinking heavily. Finally the point was reached whereby Beth could again be accepted into the group if she did something about her drinking problem. Realizing that she had to get herself under control, Beth began a three-week rehabilitation program offered by a local county agency. She was also fortunate to have a sympathetic work supervisor who allowed her time off to attend the sessions.

She found some of the programming helpful but was uncomfortable with being one of only two women in a group of 16. There was no individual counselling involved, and extensive use was made of audio-visual presentations. Beth found the material outdated and patronizing but was determined to stick it out. Throughout the three weeks, group membership changed constantly, and there were people vith varying amounts of time spent in the group.

At the end of the three-week session, it was suggested that she join an aftercare program for six months. She was told she had to attend A.A. meetings as well as the aftereare sessions. The first aftercare meeting she attended

had 45 people in attendance, and the discussions tended to focus more on the new 1988 cars rather than on alochol addiction. At the A.A. meeting she attended, she was distressed when the meeting closed with the Lord's Prayer. After the reading of the Twelve Steps of A.A., which stated that the "Power" is whatever the individual deems it to be, she felt it was restrictive for non-Christians.

Through her support group she learned of the Women for Sobriety meetings. Her attendance at these meetings had been much more fulfilling than those sponsored by Addiction Services or A.A.. For Beth her recovery has taken on new dimensions, and she feels much better about herself. She has found that the support and understanding of women who are going through or who have gone through the recovery process is very important to her.

Beth's recovery is ongoing. (March, 1988)

7. CONCLUSIONS AND RECOMMENDATIONS

The primary objective of this research project was to compile information pertaining to the treatment and programming available for women with addictions offered by the Provincial Government through Addiction Services.

The Province of Prince Edward Island accepted responsibility for treatment of addicted citizens when it established the Alcoholism Treatment Foundation in 1966. That responsibility grew as more facilities and programs were developed. Today the Province bears the financial responsibility while the County Agencies operate the facilities and programs.

Facilities:

Overall, it appears that the citizens are being well served. There are facilities in each county, operated by competent and professional staff. Occupancy rates are high and constant, and efforts are continuously made to provide services to meet the demands of the public. Outpatient programs are offered at varying times and locations, and sincere efforts are made to include the families of patients under treatment in the recovery process. Budgets are stretched to the limits according to County Directors, and dollars for new programs are virtually impossible to obtain. Right now, the Province has the highest cost-per-patient ratio in the country.

When one considers the patient without distinction according to sex, it

appears there are adequate facilities for them. There are 118 beds at all levels of treatment across the province; but only 12 of them are specifically designated for women - 10.2%. All those beds are at the detox level of treatment. There are no emergency, rehab or halfway treatment beds specifically for women in Addiction Services facilities. Both Queens and Prince Counties offer rehab beds for women, but they are shared with detox and are available only when not in use by detox patients. There has been virtually no change in the number of beds available in the last ten years.

The argument presented by Addiction Services for lack of facilities is the lack of demand and the budget restrictions to offer such services. No women are ever turned away from treatment centres, so it is felt that adequate services are being provided. Admission rates for women are 10% of the total admission rate for 1986-87, and 10% of the beds are designated female. What has changed is the percentage of women admitted. In 10 years the increase has been in Kings County from 2.8% to 4.2%, in Prince County from 8.9% to 14.8%, and in Queens County from 8.9% to 23.5%. Each service would like to have better facilities available for women, but the dollars are not available.

The lack of halfway facilities for women has been apparent for many years. The Mason Management Report of 1983 made repeated mention of that fact and recommended that something be done about it. The overall lack of facilities for women brought forward by the Mason evaluation process was never considered by Addiction Services as a priority item. There was never any further discussion on the matter.

Programs:

There are no programs specifically for women in any County Agency. Except for designated beds, women are integrated into all programs offered by the three services. As mentioned earlier in this report, County spokespersons did not consider women-only groups necessary or deisrable. One Director felt that women had to learn to live in the real world, and that world included men, and their treatment programs reflected that reality. The creation of male-only groups happened only when there were too few women in treatment or none at all.

Philosophy:

In each County there was recognition of the differences between why men drink and why women drink. But in the disease-model approach to addiction treatment, the reasons why people drink are not considered as integral to treatment. As Dr. Killorn states, "Our job is to get people to stop drinking (or taking drugs)." He feels that it is not the job of addiction workers to be social workers as well, and that happens when social conditions are blamed for an addiction. Addicts will be addicts, whether or not they are victims of incest, assault or stereotyped by society. He considers these factors as things which "defocus" the patient from concentrating on the actual drinking or drug taking. Patients are regularly referred to Social Services or other community agencies which have the expertise to deal with social problems.

Pliicy on Out-of-Province Referrals:

There is no written policy for out-of-province refereals. Referrals are made by Dr. Killorn in consultation with a recommending County Director. The cost of these treatments is quite high. Hospital and Health Services had paid out over $71,000 in the last three years for 12 women to receive treatment out of the province at an average of $5,951 per patient. These programs are of a 28-day duration, which gives a daily cost of $212.50. Possibly such programs could be developed here and thus have those dollars stay within the local economy.

New Treatment Ideas for Women:

Over the past 10 years, research and program development in the area of women and addictions has progressed in Canada. The reliance on addiction research based on male subjects has been proven as biased and unrealistic in the development of treatments for women. Programs developed through research based on female subjects are new and innovative. Much of the research in the field of women and addictions in Canada is supported by the Federal Department of National Health and Welfare, both philosophically and financially. The focus on the issue of Women and Addictions within the Federal Department is feminist based with strong emphasis on the social conditions in which women live as an influencing factor of addiction. Within P.E.I.'s Addiction Services, this philosophy is treated with disdain and great negativity.

It seems that local workers can identify with, understand and agree with the differing reasons as to why men and women drink or take drugs. But that recognition stops when it comes to treatment. There have never been any studies or concentration on the subject of women with addictions done on P.E.I. The lack of services has been identified many times over and for many years, but the commitment to do anything has been greatly lacking both at Addiction Services and within the Provincial Government.

General Ovservations:

The short time alloted this research has barely allowed for the scratching of the surface in this issue area. There was not enough time to talk in depth with workers in the field or researchers or to search out treatment programs specifically designed for women. Those whom I had the opportunity to speak with were very generous with their time and were very supportive in supplying information and statistics. People working with Islanders who have addiction problems are dedicated to improving those individuals' quality of life and deserve more support than they currently receive, both financially and morally.

Recommendations:

In truth, the only recommendation that can be made is that the need for further study in the area of women and Addictions on P.E.I. be recognized and acted upon. The whole area of addictions has not been reviewed by the Province

since the Mason Study in late 1982. This report recommends that a review of services and programs be carried out immediately and that an emphasis be put on the specific issue of women and addictions. More research is needed into programs designed for women and their special needs. Commitment by the Government to providing resources for such a review and a commitment to act on its potential recommendations are paramount. Having the highest cost per capita in the treatment of addicts is not something to brag about. It is something to be concerned about. Openness to new ideas in treatment programs and a commitment to do more than provide bandaids for those with an addiction are the keys to creating an innovative and successful system of addiction treatment. Also, it is recommended that organizations involved in addiction services, as well as other interest groups (e.g., UPEI, women's groups) apply to the National Drug Strategy Program for federal funding to sponsor a research program.

The treatment of women with addictions is not equitable to that of men. There are more facilities, beds, programs and support available for male addicts. Supports needed by women to enter treatment are not apparent. There are no childcare facilities at any level of treatment. With women having the primary responsibility for child care within the majority of Island families, they cannot simply leave their children and go into treatment. Possibly more creative programs could be designed in cooperation with Social Services to allow for the woman to enter treatment and still have her children cared for without fear of permanent removal because of an addiction. Childcare service while attending outpatient programs would be an asset. Employment upgrading and support, assertiveness training and the support of women-exclusive self-help groups are all necesssities in the successful treatment of women. Men receive a lot of these things while in

treatment. They have the opportunity to learn new job and life skills while staying in male-exclusive halfway houses. Women do not have that opportunity within current services offered by Addiction Services.

The recognition of the special needs of women with addictions is critical in any further study of addiction treatment and service. The experience of women as addicts is quite distinctive and different to that of men. The treatment of addiction should not be restricted to one line of thought. The development and study of creative and innovative treatment programs should be an on-going process.

WOMEN AND DRUGS

TEST YOURSELF ✓

1 Compared with men, how many prescriptions for minor tranquillizers do women receive?

- ☐ half as many
- ☐ almost the same
- ☐ twice as many
- ☐ three times as many

2 Women's use of minor tranquillizers decreases with age.

☐ true ☐ false

3 Doctors prescribe minor tranquillizers to men who have the same complaints as women.

☐ true ☐ false

4 Women receive twice as many prescriptions for tranquillizers as men because they visit doctors twice as often.

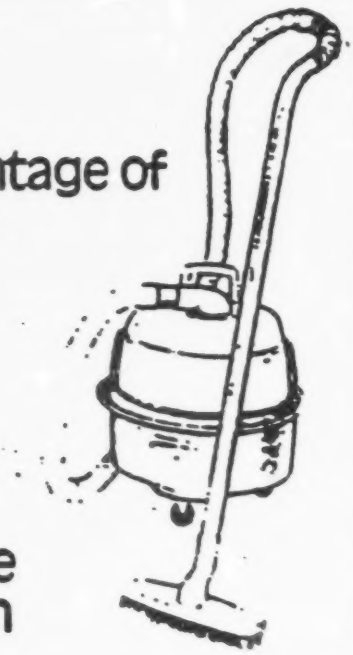
☐ true ☐ false

It's Just Your Nerves, Health & Welfare Canada.

WOMEN AND DRUGS

5 Drinking alcohol is:

- ☐ relaxing
- ☐ important to social occasions
- ☐ immoral
- ☐ better for men than women
- ☐ unhealthy



6 In the last decade, the percentage of women who use alcohol has:

- ☐ increased
- ☐ decreased
- ☐ remained the same

7 Alcohol use is increasing more rapidly among young women than among young men.

☐ true ☐ false

8 Women who are dependent on alcohol most commonly drink:

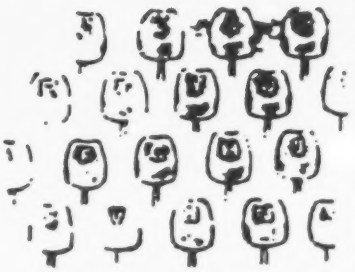
- ☐ with friends, in a bar
- ☐ on the job
- ☐ at home alone
- ☐ with family
- ☐ any of the above

It's Just Your Nerves, Health & Welfare Canada.

WOMEN AND DRUGS

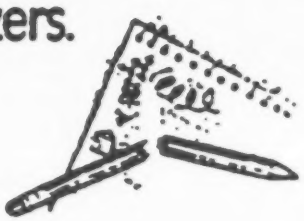
9 Women with alcohol problems are most likely to seek treatment from:

- ☐ A.A.
- ☐ doctors
- ☐ detox centres
- ☐ live-in programs
- ☐ hospitals



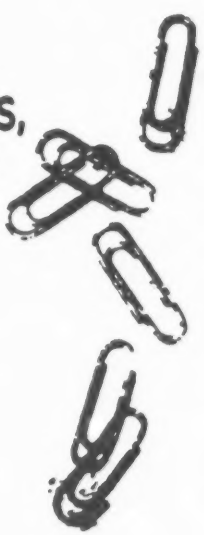
10 Women in treatment are less likely than men to be dependent on both alcohol and tranquillizers.

☐ true ☐ false



11 Women's dependence on drugs, either alcohol or minor tranquillizers, is often denied or ignored by those in a position to help (family, friends, clergy, physicians, social workers and employers.)

☐ true ☐ false



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ANSWERS TO THE QUIZ:

1. Twice as many 2. False 3. False 4. False 5. Answer may vary
6. Increased 7. True 8. Any of above 9. Doctors 10. False 11. True